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93-348

No. _____

In The
SUPREME COURT OF THE UNITED STATES
October Term, 1993

PGDH LIQUIDATING TRUST, as successor in interest to Prince George's Hospital, Incorporated, t/a Doctors' Hospital of Prince George's County,

Petitioner,

v.

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES,

Respondent.

Petition For A Writ Of Certiorari
To The United States Court of
Appeals For The Fourth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

I. Whether Congressional intent regarding a waiver statute is "clear" under *Chevron, U.S.A., Inc. v. Natural Resources Council Inc.*,[1] when the meaning of the statute is clear from the common sense understanding of the term "waiver," from the context in which the statute is to be implemented, and from the fact that the statute does not include one class of persons but does expressly include the opposite class of persons.

II. Whether *Chevron* requires a federal court to defer to the actions of a federal administrative agency when those actions are being reviewed by the court to determine if they were arbitrary and capricious, or constituted a violation of law or an abuse of discretion.

III. Whether the three-year waiver and "offset" provisions of Section 602(k) of the Social Security Amendments of 1983 were intended to achieve "budget neutrality" for each qualifying hospital, and whether the Secretary of Health and Human Services was authorized to use figures other than the Medicare "reasonable charge," consider outpatient charges as well as inpatient charges, and treat similarly-situated persons differently in computing the offset.

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[1]467 U.S. 837 (1984).

LIST OF PARTIES

The only parties to this proceeding are named in the caption: PGDH Liquidating Trust as Petitioner, and Donna E. Shalala, Secretary of Health and Human Services, as Respondent.

PGDH Liquidating Trust is the successor-in-interest to Prince George's Hospital, Incorporated, t/a Doctors' Hospital of Prince George's County. PGDH Liquidating Trust is not a parent or subsidiary of any other corporation.

Donna E. Shalala, the current Secretary of Health and Human Services, was substituted for former Secretary of Health and Human Services, Louis W. Sullivan, as the party respondent in this proceeding by the Circuit Court of Appeals for the Fourth Circuit by Order dated July 14, 1993 (Appendix at page App. 64).

TABLE OF CONTENTS

PAGE

QUESTIONS PRESENTED i

LIST OF PARTIES ii

TABLE OF AUTHORITIES vi

OPINIONS BELOW 1

JURISDICTIONAL STATEMENT 1

RELEVANT STATUTES AND REGULATIONS 2

STATEMENT OF THE CASE 2

STATEMENT OF FACTS 3

A. The General Medicare Program 4
B. Payments for "Ancillary Services" 5
C. The Section 602(k) Waiver and Offset 7
D. The Maryland Medicare Program 9
E. Particular Facts of This Case 10

REASONS FOR GRANTING THE WRIT 16

A. CERTIORARI SHOULD BE GRANTED TO REVERSE THE DECISION OF THE COURT BELOW, WHICH ACCORDED UNWARRANTED DEFERENCE TO THE SECRETARY'S INTERPRETATION AND APPLICATION OF SECTION 602(k) IN THIS CASE, AND TO CLARIFY THE SCOPE OF *CHEVRON, U.S.A., INC. v. NATURAL RESOURCES DEFENSE COUNCIL, INC.* REGARDING DEFERENCE TO ADMINISTRATIVE AGENCIES. 16

B. THE COURT BELOW INAPPROPRIATELY DEFERRED TO THE SECRETARY'S INTERPRETATION OF THE STATUTORY WAIVER IN SECTION 602(k) AND THEREFORE FAILED TO GIVE FULL EFFECT TO CONGRESS' CLEAR INTENT 19

C. THE COURT BELOW GAVE INAPPROPRIATE DEFERENCE TO THE SECRETARY'S ARBITRARY AND CAPRICIOUS APPLICATION OF THE SECTION 602(k) WAIVER IN THIS CASE. 23

1. THE SECRETARY'S FAILURE TO USE MARYLAND HEALTH SERVICES COST REVIEW COMMISSION RATES VIOLATED MARYLAND LAW, VIOLATED HIS OWN REGULATIONS, AND WAS ARBITRARY AND CAPRICIOUS. 23

2. INCLUSION OF OUTPATIENTS IN THE SECTION 602(k) OFFSET FOR PGDH, WHILE EXCLUDING OUTPATIENTS IN THE OFFSET FOR OTHER HOSPITALS, WAS IN VIOLATION OF LAW AND WAS ARBITRARY AND CAPRICIOUS. 26

3. THE SECRETARY'S DECISION TO ADJUST THE PART B OFFSET OF OTHER HOSPITALS "IN THE INTEREST OF EQUITY" AND TO AVOID A "PERVERSE EFFECT" ON BUDGET NEUTRALITY, BUT TO REFUSE TO ADJUST PGDH'S OFFSET TO ACHIEVE THE SAME RESULTS, WAS ARBITRARY, CAPRICIOUS AND AN ABUSE OF DISCRETION. 28

CONCLUSION 30
CERTIFICATE OF SERVICE 31
APPENDIX ..... App. 1

TABLE OF AUTHORITIES

PAGE

Cases

Chevron, U.S.A., Inc. v. Natural Resources Defense Council Inc., 467 U.S. 837, (1984) 16-19, 23, 26

Prince George's Doctors' Hospital, Inc. v. Health Services Cost Review Commission, 486 A.2d 744 (Md. 1985) 9, 11, 12, 24, 27, 29

Prince George's Doctors' Hospital, Inc. v. Heckler, Civil Action No. B-84-1580 (D. Md. 1984) 11

United States v. Heffner, 420 F.2d 809 (4th Cir. 1970) 26

Young v. Community Nutrition Institute, 476 U.S. 974 (1986) 17, 18

Statutes and Regulations

28 U.S.C. § 1254(1) 1

28 U.S.C. § 1291 1

42 U.S.C.A. § 1395b-1(b) (West 1992) 23

42 U.S.C.A. §§ 1395c to 1395i-4 (West 1992 and 1993 Cum. Supp.) 4

42 U.S.C.A. § 1395f(b)(1) (West 1992) 4

42 U.S.C.A. §§ 1395j to 1395w-4
(West 1992 and 1993 Cum. Supp.) 4

42 U.S.C.A. § 1395oo (West 1992) 1, 2

42 U.S.C.A. § 1395u(b)(3)(B) (West 1993
Cum. Supp.) 4, 24

42 U.S.C.A. § 1395x(e) (West 1992 Cum. Supp.) 5

42 U.S.C.A. § 1395y (West 1992) 5, 7, 20

42 U.S.C.A. § 1395y(a)(14) (West 1993
Cum. Supp.) 2, 6

Social Security Amendments of 1983, Pub. L.
No. 98-21, § 601(e), 1983 U.S.C.C.A.N.
(97 Stat.) 65, 152 (*codified as amended at*
42 U.S.C.A. § 1395ww(d) (West 1993 Cum. Supp.) .. 4

Social Security Amendments of 1983, Pub. L.
No. 98-21, § 602(e), 1983 U.S.C.C.A.N.
(97 Stat.) 65, 163 (*codified as amended*
at 42 U.S.C.A. § 1395y(a)(14) (1992) 2, 6

Social Security Amendments of 1983, Pub. L.
No. 98-21, § 602(k), 1983 U.S.C.C.A.N.
(97 Stat.) 65, 165 (*reprinted in* notes
following 42 U.S.C.A. § 1395y, at 896
(West 1992) ..... *passim*

42 C.F.R. § 405.501(a) (1991) 24

42 C.F.R. § 405.550(e) (1991) 6

42 C.F.R. § 489.23 (1985) 2, 14, 27

42 C.F.R § 489.23(c)(2)(i) (1985) 8

42 C.F.R. § 489.23(c)(3)(iii) (1985) 12, 25

Other

Black's Law Dictionary (6th ed. 1990) 23

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Popkin, William D., Materials on Legislation: Political Language and the Political Process (1993) 16, 18

S. Rep. No. 23, 98th Cong., 1st Sess. (1983), *reprinted in* 1983 U.S.C.C.A.N. 143 ..... 14, 20, 27

Sunstein, Cass R., *Law and Administration After Chevron*, 90 Colum. L. Rev. 2071 (1990) . . 17, 18

Webster's New Collegiate Dictionary (1980) 22

OPINIONS BELOW

Hearing Decision 91-4 of Provider Reimbursement Review Board (Case No. 88-0163) (Nov. 5, 1990) (Appendix pp. App. 32-61) ("App. ____.")

Opinion of the United States District Court for the District of Maryland (Civil No. B-90-3316) (Aug. 4, 1992) (unpublished) (App. 19-31).

Opinion of the United States Court of Appeals for the Fourth Circuit (No. 92-2068) (May 7, 1993) (unpublished) (App. 2-18), *reh'g denied* (June 2, 1993) (App. 62-63).

JURISDICTIONAL STATEMENT

Requesting review of a decision of the Provider Reimbursement Review Board, Petitioner timely filed suit in the United States District Court for the District of Maryland on December 21, 1990. The District Court had subject matter jurisdiction pursuant to 42 U.S.C. § 1395oo(f)(1). The decision of the District Court was appealed to the United States Court of Appeals for the Fourth Circuit pursuant to 28 U.S.C. § 1291. The United States Court of Appeals for the Fourth Circuit issued its opinion on May 7, 1993, and denied a timely Petition for Rehearing and Suggestion for Rehearing *In Banc* on June 2, 1993. The jurisdiction of this Court is invoked pursuant to the provisions of 28 U.S.C. § 1254(1).

RELEVANT STATUTES AND REGULATIONS

Section 602(k) of the Social Security Amendments of 1983, Pub. L. No. 98-21, § 602(k), 1983 U.S.C.C.A.N. (97 Stat.) 65, 165-66. The full text of this statute is set forth in the Appendix at page App. 65.

Section 602(e)(3) of the Social Security Amendments of 1983, Pub. L. No. 98-21, § 602(e)(3), 1983 U.S.C.C.A.N. (97 Stat.) 65, 163, *codified as amended at* 42 U.S.C. § 1395y(a)(14) (West 1993 Cum. Supp.). The full text of this statute is set forth in the Appendix at pages App. 66-67.

42 C.F.R. § 489.23 (1985) (which was published on September 1, 1983 as an Interim Final Rule, 48 Fed. Reg. 39838, and as a Final Rule on January 3, 1984, 49 Fed. Reg. 324). The Final Rule is reproduced in the Appendix at pages App. 69-71.

STATEMENT OF THE CASE

The Provider Reimbursement Review Board ("PRRB") issued a decision on November 5, 1990 denying Petitioner's claim for $1,579,647 in Medicare reimbursements. On December 20, 1990, the Administrator of the Health Care Financing Administration declined to review the PRRB's decision. On November 21, 1990, Petitioner filed suit in the United States District Court for the District of Maryland. The District Court had subject matter jurisdiction pursuant to 42 U.S.C. § 1395oo(f)(1). That Court issued an opinion adverse to Petitioner on August 4, 1992. Petitioner appealed that decision to the United States Court of Appeals for the Fourth

Circuit, and that Court affirmed the District Court's decision on May 7, 1993. Petitioner requested a rehearing and suggested that the case be heard *in banc*, and the United States Court of Appeals for the Fourth Circuit denied those requests on June 2, 1993. Petitioner now seeks a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit for review of that Court's decision.

STATEMENT OF FACTS

This is a case about fairness and giving full effect to Congressional intent, and about the degree to which federal courts should defer to federal administrative agencies. It is a Medicare reimbursement case that grew out of the major shift in the early 1980s in the way hospitals and doctors are paid for caring for Medicare patients. The hospital in this case, Prince George's Doctors' Hospital ("PGDH"),[2] applied for and received a "waiver" from certain of the new Medicare billing requirements. But that waiver was implemented in a way that *cost* the hospital over $1,500,000 and left the hospital in no better position -- and perhaps a worse position -- than it would have been without the waiver. Unfortunately, the facts are complex.

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[2] The Petitioner, PGDH Liquidating Trust, is the successor-in-interest to PGDH.

A. The General Medicare Program

Medicare is a two-part federal health insurance program established under the Social Security Act for eligible elderly and disabled citizens. The Health Care Financing Administration ("HCFA") administers the Medicare program for the Secretary of Health and Human Services (the "Secretary").

Part A of Medicare reimburses health care providers for specified inpatient hospital services and related post-hospital medical services provided to qualified individuals. 42 U.S.C.A. §§ 1395c to 1395i-4 (West 1992 and 1993 Cum. Supp.). Part B of Medicare provides reimbursement for certain supplementary benefits not covered by Part A, including physicians' fees and certain other medical services. 42 U.S.C.A. §§ 1395j to 1395w-4 (West 1992 and 1993 Cum. Supp.). Prior to the early 1980s, Part A charges were reimbursed on a "reasonable cost" basis, and Part B charges generally were reimbursed on a "reasonable charge" basis. *See* 42 U.S.C.A. §§ 1395f(b)(1), 1395u(b)(3)(B) (West 1992 and 1993 Cum. Supp.).

In the early 1980s, in an effort to contain medical costs, Medicare shifted its Part A payments from a "reasonable cost" reimbursement system to a prospective payment system under which Medicare makes periodic, prospective payments to a health care provider for a particular medical service based on the number of patients in a "diagnostically related group" ("DRG") it is estimated the health care provider will treat in a given year. *See* Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(e), 1983 U.S.C.C.A.N. (97 Stat.) 65, 152, *codified as amended at* 42 U.S.C.A. § 1395ww(d) (West 1993

Cum. Supp.). Part B Medicare charges are not paid under a prospective payment system; they continue to be paid, in general, on a "reasonable charge" basis.

This case involves only one aspect of these major changes in Medicare: a waiver under Section 602(k) of the Social Security Amendments of 1983 (the "Section 602(k) waiver") from certain of the new Medicare billing requirements that was intended to protect the integrity and stability of patient care at less than ten "qualifying hospitals" nationwide that were highly dependent on outside physicians who contracted with these hospitals -- called "outside suppliers" -- to provide certain "ancillary services," such as radiology and X-rays, to Medicare patients. *See* Social Security Amendments of 1983, Pub. L. No. 98-21, § 602(k), 1983 U.S.C.C.A.N. (97 Stat.) 65, 165 (*reprinted in* notes following 42 U.S.C.A. § 1395y, at 896 (West 1992)) (App. 65). PGDH was one of the hospitals that received a Section 602(k) waiver.

B. Payments for "Ancillary Services"

In order to be eligible to participate in the Medicare program, a hospital must provide certain services, *see* 42 U.S.C.A. § 1395x(e) (West 1993 Cum. Supp.), including certain "ancillary services" -- those services "customarily billed along with room, board, and nursing care" such as "radiology, pathology, and nuclear medicine . . . ." Appendix at p. App. 4 ("App. __"). Ancillary services are provided either by the hospital itself or by certain outside physicians -- known as

"outside suppliers" -- who contract with the hospital. Hospitals are reimbursed for ancillary services through Part A of Medicare and outside suppliers through Part B. *Id.* at 4-5.

Ancillary services have two components: the physician or "professional" component (e.g., a physician's fee for interpreting an x-ray) and a non-physician or "technical" component (e.g., the overhead, personnel and equipment necessary to take an x-ray). *Id.* Prior to the Medicare reforms of the early 1980s, outside suppliers who provided ancillary services to Medicare patients traditionally did not segregate their charges into the professional component and the technical component but, instead, billed Part B of Medicare for a single "unitary charge." *See id.* at 5, 9.

In 1983, as part of its efforts to contain medical costs, Congress decided to stop paying outside suppliers for the technical component of their ancillary services under the Part B "reasonable charge" reimbursement system and, instead, to pay hospitals directly for that component under Part A of Medicare pursuant to the new prospective payment system. The result was that outside suppliers may now bill Part B of Medicare only for their professional services; the technical component is to be billed by the hospital through Part A. *See* Social Security Amendments of 1983, Pub. L. No. 98-21, § 602(e)(3), 1983 U.S.C.C.A.N. (97 Stat.) 65, 163, *codified as amended at* 42 U.S.C.A. § 1395y(a)(14) (West 1993 Cum. Supp.) (App. 66-67); 42 C.F.R. § 405.550(e) (1991).

C. *The Section 602(k) Waiver and Offset*

"Because of these significant changes in the Medicare program, Congress recognized that some hospitals . . . [which] relied heavily on outside suppliers [for ancillary services] might need time to adjust their billing practices." App. 6. Congress therefore included in the Social Security Amendments of 1983 a waiver provision -- known as the "Section 602(k) waiver" -- under which outside suppliers associated with a limited number of "qualifying hospitals" could continue to bill Part B for the technical component of their ancillary services as part of a unitary charge for up to three years. Specifically, Section 602(k) provided, in part, that the Secretary could grant the waiver:

> in the case of a hospital which has followed a practice, since prior to October 1, 1982, of allowing direct billing under part B of . . . [Medicare] for services (other than physicians' services) so extensively, that immediate compliance with those requirements would threaten the stability of patient care.

Social Security Amendments of 1983, Pub. L. No. 98-21, § 602(k), 1983 U.S.C.C.A.N. (97 Stat.) 65, 165 (*reprinted in* notes following 42 U.S.C.A. § 1395y, at 896 (West 1992)) (App. 65).

In order to show a potential threat to the stability of patient care and qualify for the waiver, a hospital had to demonstrate its dependence on outside suppliers. As evidence that a major financial disruption would occur if the technical

component no longer could be billed to Part B by the outside supplier, the hospital had to show that the outsider supplier's Part B "reasonable charges" for the technical component were at least 125 percent of the "reasonable cost" of the technical component for the same services furnished by the hospital itself. *See* 42 C.F.R § 489.23(c)(2)(i) (1985) (App. 70-71).

If a hospital qualified for the Section 602(k) waiver, its outside suppliers could continue to bill Part B of Medicare directly for the technical component of its ancillary services. Since the Section 602(k) waiver did not affect the newly-enacted prospective payment system under Part A of Medicare, however, Medicare also paid the hospital for those same technical component charges under Part A. In order to prevent double payment by Medicare, therefore, Congress also provided in Section 602(k) that "the payments to such hospital under Part A of . . . [Medicare] shall be reduced by the amount of the billings for such services [by the outside supplier] under Part B. . . ." App. 65.

This case involves a dispute over how the Part B "offset" was calculated. PGDH's expectation was that the offset would be budget neutral -- *i.e.*, that the Part B offset would not exceed the Part A payment. As calculated by the Secretary, however, PGDH's Part B offset exceeded its Part A payments by over $1,500,000, resulting in a loss to PGDH of that amount.

D. The Maryland Medicare Program

One further fact complicating this case is that Maryland has a different system from the general system described above for the reimbursement of Medicare charges. Prior to the Medicare reforms of the early 1980s, Maryland had received a "demonstration project" waiver from the Secretary, allowing it to establish its own prospective payment system for the reimbursement of hospitals; that waiver was continued after the Medicare reforms of the early 1980s. *See* Record at 1249-51, *PGDH Liquidating Trust v. Sullivan*, Civil No. B-90-3316 (D. Md. 1992) (administrative record before the District Court) ("R. at ____"). Under Maryland's demonstration project, the Maryland Health Services Cost Review Commission ("HSCRC") establishes its own rates and prospective payment system for the reimbursement of hospitals. App. 8. The Court below found that the Maryland demonstration project applied only to Part A reimbursements, and that "Maryland's system did not address Part B principles of reimbursement." *Id.*

A major dispute arose, however, between PGDH and the HSCRC over the reach of HSCRC's rates:

> Specifically, because Maryland's demonstration project –only regulated hospital rates, PGDH believed that the HSCRC rates could not regulate the charges for the technical component of ancillary services provided by outside suppliers. However, in January 1985, the Maryland Court of Appeals rejected PGDH's claim in *Prince George's*

> *Doctor's Hospital, Inc. v. Health Services Cost Review Commission*, 486 A.2d 744 (Md. 1985), holding that the HSCRC rates applied to the technical component of ancillary services regardless of who supplied the services.

App. 8-9. Thus, after this 1985 Maryland Court of Appeals decision, HSCRC rates for ancillary services, including charges for the technical component of those services, were the legal Medicare rates in Maryland.

E. Particular Facts of This Case

PGDH applied for a Section 602(k) waiver on August 22, 1983. R. at 1015. To qualify for the waiver, of course, PGDH had to demonstrate that its outside suppliers' technical component charges were 125 percent of PGDH's own "reasonable cost" for those same services (the "125% test"). Since outside providers traditionally had billed Part B of Medicare using a "unitary charge" for both the professional component and technical component of the ancillary services they provided, however, PGDH and its outside suppliers did not have past technical component charges broken out and readily available.

After working with HCFA over several months to try to determine an acceptable basis for estimating the technical component charges and satisfying the 125% test, PGDH submitted two schedules: Schedule I, which was based on the estimated percentages of its outside suppliers' own annualized charges for the technical component of ancillary services

provided to inpatients at PGDH, and Schedule II, which used estimated percentages for these same charges based on statewide averages developed by PGDH's consultants. R. at 1233, 1234; App. 9-10. Both Schedules met the 125% test, but when asked by the Secretary to select one of the two, PGDH understandably selected the higher of the two, Schedule II, to ensure that it qualified for the waiver. R. at 438. The Secretary granted PGDH's request for a Section 602(k) waiver on December 30, 1983. R. at 1236-38.

The granting of the waiver did not, however, automatically trigger the Section 602(k) offset. During its dispute with the Maryland HSCRC over whether HSCRC rates applied to outside suppliers' charges for the technical component of ancillary services, PGDH never billed Part A for those charges. Only the outside suppliers had received payment for those charges, under Part B. App. 10. Since there had been no double billing, therefore, on July 3, 1984, at PGDH's request, the United States District Court for the District of Maryland enjoined the Secretary from offsetting against PGDH's Part A payments the amount of any payments for the technical component of ancillary services which had been received by PGDH's outside suppliers. Order and Judgment, *Prince George's Doctors' Hospital, Inc. v. Heckler*, Civil Action No. B-84-1580 (D. Md., July 3, 1984) (R. 1309-10).

Following the Maryland Court of Appeals' decision on January 16, 1985, in *Prince George's Doctors' Hospital, Inc. v. Health Services Cost Review Commission*, 486 A.2d 744, 750-51 (Md. 1985) ("*PGDH v. HSCRC*"), that the Maryland HSCRC

had the authority to regulate rates for the technical component of ancillary services provided by outside suppliers, the injunction issued by the United States District Court for the District of Maryland dissolved. PGDH was paid retroactively under Part A -- at HSCRC rates -- for the technical component of ancillary services provided to Medicare patients by PGDH's outside suppliers since the inception of the PGDH's Section 602(k) waiver, and, to avoid a double payment, the Secretary imposed a retroactive offset under Section 602(k) -- using PGDH's Schedule II rates. App. 10-11.

PGDH disputed the use of the Schedule II rates to calculate the actual amount of the offset, arguing that after the Maryland Court of Appeals' decision in *PGDH v. HSCRC*, the HSCRC rates governed the rates outside suppliers could charge for the technical component and that HCFA had a responsibility to ensure that no more than the HSCRC rates were in fact being charged. The Secretary's own regulations required that outside suppliers must agree to "identify the nonphysician [technical] services that were furnished, and identify the charge for each service" before the Section 602(k) waiver was to be issued. 42 C.F.R. § 489.23(c)(3)(iii) (1985) (App. 71). Yet, HCFA did not insist that PGDH's outside suppliers submit separate, actual charges for the technical component. Instead, HCFA determined that it was satisfied with applying the Schedule II rates to the "unitary charge" containing both the professional and technical component and that such an approach would "produce the same result or an equitable result." *See* R. at 242, 283-85, 1240-42.

Nonetheless, the Court below held that "[b]ecause PGDH's outside suppliers had submitted unitary billings to Medicare for Part B reimbursement, the Secretary had no information indicating the actual amounts which Medicare had already paid to outside suppliers for the technical component of ancillary services" and, essentially, had no choice but to use the Schedule II percentages to calculate the appropriate Section 602(k) offset. App. 11, 15.

The Court below used the following example to illustrate the impact of the use of the Schedule II rates to calculate the Part B offset in this case:

> To fully illustrate the effects of this procedure, we use the same example relied on by the district court. Suppose PGDH's outside supplier (a radiologist) submitted a unitary bill for $100 to Medicare for reimbursement under Part B, reflecting charges for both the professional and technical component of ancillary services provided. To determine the amount attributable to the charges for the technical component of ancillary services, the Secretary applied the appropriate Schedule II percentage (83.5 percent). Thus, the Secretary determined that $83.50 from the outside supplier's unitary bill constituted charges for the technical component. At the same time, PGDH billed Medicare under Part A for the same services; however, the HSCRC set the rate at which PGDH could bill Medicare for these services at $60.00. Consequently, the amount which PGDH received under Part A for the technical component of ancillary services provided by outside suppliers ($60.00) was less than PGDH's offset for

> these same services ($83.50). This discrepancy resulted in a net reduction to PGDH's Part A payments of $23.50. PGDH claims that this methodology inflicted an overall reduction of $1,579,647 to its Part A payments from Medicare.

App. 11-12 n.5.

The Secretary also included PGDH outpatients as well as inpatients in the offset calculation. R. at 1240. The legislative history of the prospective payment provisions of the Social Security Amendments of 1983, the Secretary's regulations implementing the Section 602(k) waiver, and HCFA's communications regarding the waiver, however, all clearly indicated that the Section 602(k) waiver was to apply to inpatient services only. *See e.g.*, S. Rep. No. 23, 98th Cong., 1st Sess. 48 (1983), *reprinted in* 1983 U.S.C.C.A.N. 143, 188; 42 C.F.R. § 489.23 (1985) (App. 69-71); Health Care Financing Administration, Department of Health and Human Services, *Medicare Provider Reimbursement Manual*, Part 1, Transmittal No. 299 (Sep. 1983) (R. at 1207-10).

Finally, in order to avoid a "perverse effect" and "in the interest of equity," the Secretary, through HCFA, worked with other hospitals that had been granted a Section 602(k) waiver and made adjustments in their Part B offset to achieve no net reduction in their Part A payments -- i.e., to achieve budget neutrality. *See* R. at 866-67, 869-70. With St. Mary's Hospital and the Rochester Methodist Hospital of Minnesota, the hospitals serviced by the Mayo Clinic, the Secretary reduced the offset by deducting certain capital and educational costs.

R. at 866-67. In the case of the Carle Foundation Hospital, the Secretary delayed the effective date of the offset and, in addition, worked with the hospital in an effort to develop the actual ancillary charges for 174 separate medical procedures, although they apparently were able to develop charges for only 86 procedures. R. at 578, 906A-906B. The Secretary also reduced the offset to achieve budget neutrality. R. at 869-70. In the case of PGDH, however, the Secretary did not apply the waiver to achieve budget neutrality. Instead, he[3] applied the waiver in a way that caused PGDH to lose over $1,500,000.

PGDH challenged the offset calculation before the Provider Reimbursement Review Board, which upheld the calculation, App. 60, and then sought judicial review of that decision in the United States District Court for the District of Maryland. The district court affirmed the Board, App. 31, and the Court below affirmed the district court. App. 18.

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[3] Louis W. Sullivan was the Secretary of Health and Human Services at the time of this suit. Donna E. Shalala has since been substituted by the Court below as the party respondent. *See* App. 64.

REASONS FOR GRANTING THE WRIT

Although this case is complex factually, from a policy perspective it is quite simple. It is a case about fairness and giving full effect to Congressional intent, and about the degree to which federal courts should defer to federal administrative agencies.

A

CERTIORARI SHOULD BE GRANTED TO REVERSE THE DECISION OF THE COURT BELOW, WHICH ACCORDED UNWARRANTED DEFERENCE TO THE SECRETARY'S INTERPRETATION AND APPLICATION OF SECTION 602(k) IN THIS CASE, AND TO CLARIFY THE SCOPE OF *CHEVRON, U.S.A., INC. v. NATURAL RESOURCES DEFENSE COUNCIL, INC.*[4] REGARDING DEFERENCE TO ADMINISTRATIVE AGENCIES.

This case does arise in the context of a complex federal health care statute -- Medicare -- and it therefore is tempting for federal courts to give almost complete deference -- indeed, to abdicate -- to HCFA and the Secretary in interpreting and administering the statute. But this case goes too far.

Much has been written about the reach of this Court's decision in *Chevron, U.S.A., Inc. v. Natural Resources Council, Inc.*, 467 U.S. 837 (1984) and the degree to which federal courts should defer to federal administrative agencies. *See, e.g.*, William D. Popkin, Materials on Legislation: Political

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[4]467 U.S. 837 (1984).

Language and the Political Process § 1404 at 531-54 (1993); Cynthia R. Farina, *Statutory Interpretation and the Balance of Power in the Administrative State*, 89 Colum. L. Rev. 452 (1989); and Cass R. Sunstein, *Law and Administration After Chevron*, 90 Colum. L. Rev. 2071 (1990). In *Chevron*, this Court held that:

> When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.

Chevron, 467 U.S. at 842-43 (footnotes and citations omitted). *Accord. Young v. Community Nutrition Institute*, 476 U.S. 974, 980-81 (1986). This Court also noted that:

> The judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear

> congressional intent. . . . If a court, employing traditional tools of statutory construction, ascertains that Congress had an intention on the precise question at issue, that intention is the law and must be given effect.

Chevron, 467 U.S. 843 n.9 (citations omitted). In the absence of clear Congressional intent, however, "the only further judicial inquiry is whether the agency's interpretation is a rational one." Farina, *supra*, at 459, *citing Chevron*, 467 U.S. at 843. Once it concludes that Congress did not have a "specific intention" regarding the meaning of a statute, a federal court should confine itself to asking whether the agency's interpretation was reasonable. *Chevron*, 467 U.S. at 845; Farina, *supra*, at 460; Sunstein, *supra*, at 2084. The full scope of this "super-deferential" approach of *Chevron* has not yet been defined by the Court. *See* Popkin, *supra*, at 536. For example, how does a court determine when Congressional intent is "clear" enough to warrant rejection of a contrary administrative interpretation? *Id.* at 542-48. *See Young*, 476 U.S. at 980-81, 985-88.

This much *is* clear, however. When Congress *has* expressed its intent, federal administrative agencies must faithfully adhere to that intent and any contrary administrative interpretation must be rejected. *Chevron*, 467 U.S. at 482-83 and n.9. Furthermore, there is nothing in *Chevron* that would weaken the time-honored administrative law principles that an administrative agency must abide by its own regulations and that it may not act arbitrarily or capriciously or abuse its

discretion in administering the program for which it is responsible.

This case involves a failure by HFCA and the Secretary, and the courts below, to give full effect to clear Congressional intent regarding the Section 602(k) waiver for hospitals that were heavily dependent upon outside suppliers to provide ancillary services to Medicare patients, a failure by the Secretary to follow his own regulations, and an arbitrary and capricious application of the Section 602(k) waiver to the hospital in this case, amounting to a clear abuse of discretion. This Court should grant a writ of certiorari to the Court below to clarify that *Chevron* requires administrative agencies to adhere to clear expressions of Congressional intent and to follow their own regulations, and that *Chevron* does not require a federal court to abdicate its judicial review responsibilities by according "super-deference" to agency actions that are being reviewed to determine whether they are arbitrary and capricious, or constitute an abuse of discretion or a violation of law.

B

THE COURT BELOW INAPPROPRIATELY DEFERRED TO THE SECRETARY'S INTERPRETATION OF THE STATUTORY WAIVER IN SECTION 602(k) AND THEREFORE FAILED TO GIVE FULL EFFECT TO CONGRESS' CLEAR INTENT.

This case also arises in a substantive area in which there is virtually no case law. Thus, the focus must be almost

exclusively on the policy and Congressional intent underlying the relevant statutes.

There are three aspects of the Medicare reforms of the early 1980s that are relevant to a determination of Congress' intent regarding implementation of the Section 602(k) waiver. The first aspect was the shift of Medicare from a reimbursement system to a prospective payment system. The primary purpose of this shift was, of course, cost containment. *See* App. 16 n.6; S. Rep. No. 23, 98th Cong., 1st Sess. 47 (1983), *reprinted in* 1983 U.S.C.C.A.N. 143, 187.

The clear purpose of the Section 602(k) waiver, however, was to provide temporary *relief* from this new system to a certain limited number of hospitals that were highly dependent on outside suppliers for key ancillary services for Medicare patients. Social Security Amendments of 1983, Pub. L. No. 98-21, § 602(k), 1983 U.S.C.C.A.N. (97 Stat.) 65, 165-66 (*reprinted in* notes following 42 U.S.C.A. § 1395y, at 896 (West 1992)). The effect of the Section 602(k) waiver was to protect the financial stability of these hospitals, and the integrity and stability of patient care provided by these hospitals and their outside suppliers, by giving them a transition period of up to three years to adjust to the new Medicare billing procedures, to complete the difficult and time-consuming process of determining how much of each outside supplier's "unitary charge" was in fact attributable to the technical component, and to make the changes in health care delivery necessary to reduce the cost of their technical component.

Finally, the purpose of the offset required by Section 602(k) was to avoid double payment by Medicare. The goal was budget neutrality. Even HCFA recognized that the offset was to be "dollar-for-dollar." R. at 866 (internal HCFA memorandum, dated July 5, 1984). Indeed, HCFA made it clear that the overall goal for the entire Medicare system during the shift to a prospective payment system was budget neutrality:

> [D]uring the first two years of the transition period, aggregate payments under the prospective payment system *will be adjusted*, in accordance with section 1886(e)(1) of the [Social Security] Act, to be *"budget neutral"*; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be *neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Act in effect before April 20, 1983.*

Health Care Financing Administration, Department of Health and Human Services, *Medicare Program; Prospective Payment for Medicare Inpatient Hospital Services; Final Rule,* 49 Fed. Reg. 234, 303 col. 2 (1984) (emphasis added).

Thus, in simple mathematical terms, the purpose of the § 602(k) waiver was to ensure that:

Part A - Part B = approximately 0

The Court below addressed this critical issue of Congressional intent only in a footnote and, without citation to authority, held that, since the purpose of shifting Medicare to a prospective payment system was cost containment, and since the amounts being paid to outside suppliers under Part B of Medicare in general were higher than what was anticipated would be paid to hospitals under Part A, "we believe that Congress recognized" that the payments under Part B would not "exactly equal" the payments under Part A. App. 16 n.6. Thus, Congress must have recognized that the result would be a loss for some hospitals.

While this reasoning may be correct for a hospital that did not receive a Section 602(k) waiver, it ignores the fact that the purpose of the waiver was to provide *relief* from this effect for a limited number of hospitals that were heavily dependent upon outside suppliers, in order to protect the integrity and stability of patient care at, and the financial stability of, those hospitals. In the case of PGDH, however, the Secretary's application of the Section 602(k) waiver resulted in a *loss* of over $1.5 million in the amount the Part B offset exceeded payments under Part A. App. 11-12 n.5, 33.

Even if Congress did not intend that the Part B offset would be "exactly equal" to the Part A payments, it could not have intended that a "waiver" would result in a $1.5 million *loss* to a hospital that supposedly was being granted relief from the new Medicare billing requirements. To "waive" means "to refrain from pressing or enforcing . . . a claim or rule . . . ." Webster's New Collegiate Dictionary 1306 (1980); *accord.*

Black's Law Dictionary 1580 (6th ed. 1990). The effect of the Secretary's application of the Section 602(k) waiver in this case, however, is that PGDH is in no better position -- and perhaps is in a worse position -- than it would have been without the waiver. This cannot be consistent with Congress' intent, and by affirming the Secretary, the district court in this case and the Court below grossly misinterpreted and therefore failed to give full effect to Congress' intent with regard to the Section 602(k) waiver. In the face of clear Congressional intent, this degree of deference to the Secretary in interpreting a federal statute, even a complex statute, is unwarranted. *See Chevron*, 467 U.S. at 842-43 and n.9.

C

THE COURT BELOW GAVE INAPPROPRIATE DEFERENCE TO THE SECRETARY'S ARBITRARY AND CAPRICIOUS APPLICATION OF THE SECTION 602(k) WAIVER IN THIS CASE.

1. **THE SECRETARY'S FAILURE TO USE MARYLAND HEALTH SERVICES COST REVIEW COMMISSION RATES VIOLATED MARYLAND LAW, VIOLATED HIS OWN REGULATIONS, AND WAS ARBITRARY AND CAPRICIOUS.**

Maryland is a Medicare "demonstration project" state; as such, the Maryland Health Services Cost Review Commission ("HSCRC") is authorized by the Secretary to set Medicare rates in Maryland. 42 U.S.C.A. § 1395b-1(b) (West 1992); R. at 1249-51. PGDH had been disputing for years the authority

of HSCRC to set any portion of the Medicare rates for outside suppliers. However, in 1985 in *Prince George's Doctors' Hospital, Inc. v. Health Services Cost Review Commission*, 486 A.2d 744, 750-751 (Md. 1985) ("*PGDH v. HSCRC*"), the Maryland Court of Appeals held that HSCRC, pursuant to its "demonstration project" authorization from the Secretary, did indeed have the authority to set rates for outside suppliers, including the allowable rate for the technical component of their ancillary services. After 1985 in Maryland, therefore, the HSCRC rate was *the* legal rate for the technical component for *both* in-house hospital physicians *and* outside suppliers, and thus became the "reasonable charge" outside suppliers may charge under Part B of Medicare. The Secretary, through HCFA, had a statutory duty to reimburse outside suppliers only for their "reasonable charge" for the technical component. *See* 42 U.S.C.A. § 1395u(b)(3)(B) (West 1993 Cum. Supp.); 42 C.F.R. § 405.501(a) (1991). Thus, the Secretary had a legal duty to determine the actual experience of PGDH's outside suppliers to ensure that no more than the HSCRC rate was being charged for the technical component.

Nonetheless, even after the 1985 *PGDH v. HSCRC* decision, the Secretary continued to insist that the Schedule II figures that PGDH had elected to rely upon to qualify for the Section 602(k) waiver be used for Part B offset purposes, even though there was no evidence that PGDH's outside suppliers actually charged at the Schedule II rates. *See generally* App. 15. Indeed, the chief executive officer of

PGDH testified that the Schedule II figures bore "no relation" to actual charges. R. at 438. The Schedule II figures were the statewide average technical component charges of outside suppliers and had been used by PGDH because, like other hospitals, it did not have actual figures for the technical component charges of outside suppliers at the time of its waiver application. *Id.*

This use by the Secretary of the Schedule II rates, however, also violated the Secretary's own regulations. Those regulations require that outside suppliers must agree to "identify the nonphysician [technical] services that were furnished, and identify the charge for each service" before the § 602(k) waiver will be granted to the hospital. 42 C.F.R. § 489.23(c)(3)(iii) (1985) (App. 71). It was the duty of the Secretary, through HCFA, to enforce the law and deny the waiver or payment if the actual technical component charges were not submitted by the outside suppliers. Instead, HCFA decided that such a calculation would be "cumbersome administratively" and would have "no meaning" and, therefore, in order "to avoid a service by service evaluation," HCFA decided it was satisfied with applying the Schedule II rates to the "unitary charge" containing both the professional and technical component, "to produce the same result or an equitable result." *See* R. 242, 283-85, 1240-42. The actual amounts charged for the technical component by PGDH's outside suppliers could have been determined if HCFA had insisted upon submission of the data as a condition of the waiver, as is required by the Secretary's regulations, or as a

condition of continued payments to the outside suppliers. Instead, HCFA in effect rewrote the regulations to produce what its staff thought was "the same result or an equitable result." R. at 283.

An administrative agency may not, of course, ignore the requirements of a statute or its own regulations. *See Chevron*, 467 U.S. at 842-43. As the Court below held on another occasion:

> An agency of the government must scrupulously observe rules, regulations, or procedures which it has established. When it fails to do so, its action cannot stand and courts will strike it down.

United States v. Heffner, 420 F.2d 809, 811 (4th Cir. 1970). The Secretary's use of the Schedule II rates in this case, therefore, was a violation of law and was arbitrary and capricious, and the decision of the Court below to uphold the Secretary gave inappropriate and undue deference to the Secretary.

2. INCLUSION OF OUTPATIENTS IN THE SECTION 602(k) OFFSET FOR PGDH, WHILE EXCLUDING OUTPATIENTS IN THE OFFSET FOR OTHER HOSPITALS, WAS IN VIOLATION OF LAW AND WAS ARBITRARY AND CAPRICIOUS.

The legislative history of the prospective payment provisions of the Social Security Amendments of 1983, the Secretary's regulations implementing the Section 602(k) waiver, and HCFA communications regarding the waiver

clearly indicate that the waiver was to apply to inpatient services only. *See e.g.*, S. Rep. No. 23, 98th Cong., 1st Sess. 48 (1983), *reprinted in* 1983 U.S.C.C.A.N. 143, 188; 42 C.F.R. § 489.23 (1985) (App. 69-71); Health Care Financing Administration, Department of Health and Human Services, *Medicare Provider Reimbursement Manual*, Part 1, Transmittal No. 299 (Sep. 1983) (R. at 1207-10). Furthermore, in applying the waiver to other hospitals, the Secretary did not include in the offset payments for services provided to outpatients. *See Medicare Provider Reimbursement Manual*, Part 1, Transmittal No. 299, *supra*. In the case of PGDH, however, the Secretary included outpatients as well as inpatients in the offset. The Secretary's reason for doing so was the determination by HSCRC that its rates, under its "demonstration project" authorization, applied to outpatients as well as inpatients. R. at 1240. In the absence of statutory authority to do so, however, this was not a sufficient reason for the Secretary to include outpatient services in PGDH's offset. Such authorization did not exist in this case.

Finally, the Secretary's reliance here on Maryland law, as interpreted by the HSCRC, to include outpatients in the Part B offset calculation is inconsistent with his earlier decision not to apply Maryland law (the HSCRC rate pursuant to *PGDH v. HSCRC*) to determine the appropriate amount of the offset. The only consistency in the two decisions is that both times the Secretary chose the figure that would increase the Part B offset and decrease the net amount paid to PGDH under Part A.

In the absence of the necessary statutory authority, in light of the fact that payments for services provided to outpatients were not included in the Section 602(k) Part B offset for other hospitals, and in light of his inconsistent and selective use of Maryland law, the Secretary's decision to include outpatient services in PGDH's Section 602(k) Part B offset was in violation of law and was arbitrary and capricious.

Although the Secretary's decision to include outpatients in PGDH's Part B offset was addressed by PGDH on appeal to the Court below, the issue was not addressed by the Court. *See* App. 2-18; Appellant's Brief at 32, *PGDH Liquidating Trust v. Sullivan*, No. 92-2068 (4th Cir. 1993).

3. THE SECRETARY'S DECISION TO ADJUST THE PART B OFFSET OF OTHER HOSPITALS "IN THE INTEREST OF EQUITY" AND TO AVOID A "PERVERSE EFFECT" ON BUDGET NEUTRALITY, BUT TO REFUSE TO ADJUST PGDH'S OFFSET TO ACHIEVE THE SAME RESULTS, WAS ARBITRARY, CAPRICIOUS AND AN ABUSE OF DISCRETION.

In order to avoid a "perverse effect" and "in the interest of equity," the Secretary, through HCFA, worked with other hospitals and made adjustments in their Part B offset to achieve the overall goal of budget neutrality. R. at 866-67, 869-70. With St. Mary's Hospital and Rochester Methodist Hospital of Minnesota, the hospitals serviced by the Mayo Clinic, the Secretary reduced the offset by deducting certain capital and educational costs. R. at 866-67. In the case of the Carle Foundation Hospital, the Secretary delayed the effective

date of the offset and, in addition, worked with the hospital in an effort to develop the actual ancillary charges for a number of separate medical procedures. R. at 578, 906A-906B. He also reduced the offset to achieve budget neutrality. R. 869-70. Thus, at least with these three hospitals, when the Secretary determined that the Part B offset would be in excess of the Part A payments to the hospital, he worked with the hospital either to reduce or delay the offset in order to achieve budget neutrality, or to determine the actual amounts of the components of the ancillary charges, or both. This certainly was consistent with the overall intent of Congress that the Section 602(k) waiver be administered in such a manner that the Part B offset would equal or approximate the Part A payments to the hospital.

In the case of PGDH, however, the Secretary did not apply the waiver to achieve budget neutrality. After *PGDH v. HSCRC* in 1985, Medicare was required by law to pay the hospital under Part A no more than the HSCRC rate for the technical component. *See PGDH v. HSCRC, supra*. Thus, in order to treat PGDH fairly, to be consistent with the manner in which he had treated other hospitals, and to achieve or approximate budget neutrality, the Secretary also should have used the HSCRC rate for PGDH's Part B offset, as required by Maryland law under *PGDH v. HSCRC*, to avoid a "perverse effect" and "in the interest of equity." The Secretary's failure to do so was arbitrary, capricious and an abuse of discretion, and the decision of Court below to uphold the Secretary,

therefore, gave inappropriate and undue deference to the Secretary's determination.

CONCLUSION

The Court of Appeals accorded undue deference to the Secretary's clearly erroneous interpretation of Section 602(k) of the Social Security Amendments of 1983, to his failure to follow his own regulations, and to his arbitrary and capricious application of the Section 602(k) waiver in this case. For these reasons, the Court of Appeals' ruling should be reversed and this Petition for a Writ of Certiorari should be granted.

This 31st day of August, 1993.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this 31st day of August 1993, in compliance with Rule 29 of the Rules of the United States Supreme Court, three true copies of the foregoing Petition for Writ of Certiorari were sent by first class mail, postage prepaid, to:

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